(C) M-3 (Calculation of reimbursement settlement for RHC services).

(D) M-5 (Analysis of payments to hospital-based RHC services rendered to program beneficiaries).

(E) S-8 (Statistical Data/Information Purposes).

(F) RHC net expenses for allocation of costs for services rendered on or after January 1, 1998, reported on the hospital's worksheet A, column 7 trace properly to the RHC's total facility costs on line 32, column 7 on M-1 worksheet.

(G) Hospital's overhead worksheet expenses allocated to each of the hospital-based RHC cost centers on worksheet B, Part I (column 27 minus column 0) trace properly to line 15, column 5 on M-2 worksheet for each hospital-based RHC..

(2) For a freestanding RHC, a complete HCFA 222 Form and HCFA 339 form with Certification by an Officer of Administrator.

(n) Once the base rate for an RHC has been calculated, the RHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (o), a cost report shall only be required if the RHC is seeking to adjust its effective rate.

(o) New RHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the RHC's reasonable costs anticipated to be incurred during the RHC's initial fiscal year. RHC shall file a cost report within five (5) months of the end of RHC's initial fiscal year. The cost settlement must be completed within six (6) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new RHC location established by an existing RHC participating in the Medicaid program shall receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(p) In the event that the total amount paid to an RHC by a managed care organization is less than the amount that the RHC would receive under PPS, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient cost or bonuses.

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(q) Submission of Audited Medicare Cost Reports. An RHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.

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31. Federally Qualified Health Centers (FQHC):

For services provided by an FQHC and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

For FQHC facilities employing the Prospective Payment System Methodology.

(a) In accordance with Section 1902 (aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the FQHC's fiscal year which includes dates of service occurring January 1, 2001, and after, FQHC's will be reimbursed a PPS per visit rate for Medicaid covered services. There will no longer be a cost settlement for FQHCs for dates of services on or after January 1, 2001.

(b) The PPS per visit rate for each FQHC will be calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.

(c) Prior to the commission setting a PPS rate pursuant to subsection (a), each FQHC will be reimbursed on the basis of an interim per visit rate. The interim per visit rate for each FQHC will be the encounter rate from the latest finalized cost report settlement, adjusted as provided for in Subsection (h). When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001. The final PPS rate, as adjusted, will apply prospectively from the date of the final approval.

(d) Reasonable costs, as used in setting the base rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413 with no productivity screens and no per visit payment limit. The administrative cost limit of thirty percent (30%) of total costs that was in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.

(e) Unallowable costs are expenses which are incurred by an FQHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not

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necessarily limited to, the following:

(1) Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(2) Personal expenses not directly related to the provision of covered services;

(3) Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(4) Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(5) Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(6) Political contributions;

(7) Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(8) Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the

development and operation of patient care facilities and programs, or the rendering of patient care services;

(11) Entertainment expenses except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director's fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the FQHC;

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(22) Overhead costs beyond the 30% limitation established by the HHSC.

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(f) A visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The FQHC patient has a medical visit and an "other" health visit.

(g) A medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse mid-wife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face encounter between an FQHC patient and a clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, a Texas Health Steps Medical Screen, or a health care orientation as required by HHSC.

(h) Effective for each FQHC's fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an FQHC's base per visit rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for primary care.

(i) The effective rate is the rate paid to the FQHC for the current fiscal year. The effective rate equals the base rate plus the MEI for each of the FQHC's fiscal years since the setting of its base rate. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year.

(j) An adjustment shall be made to the effective rate if the FQHC can show that the increase is due to a change in scope. An FQHC or the commission may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by filing a cost report and the necessary documentation to support a claim that the FQHC has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an FQHC's fiscal year but no later than five (5) calendar months after the end of the FQHC's fiscal year. All requests for adjustment in the FQHC's effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation supporting the FQHC's claim that it has undergone a change in scope. ~~Within sixty (60) days of~~

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submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All adjustments shall be calculated using the effective rate and shall be applied prospectively.

(k) Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC has had a change in scope. A change in scope of services provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an FQHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(l) A workable cost report includes the following:

(1) An FQHC Statistical Data Coversheet with Certification by an Officer or Administrator;

(2) Medicaid Cost Report consisting of three (3) worksheets:

(A) Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses;

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(B) Worksheet 2 – Provider Staff and Encounters; and

(C) Worksheet 3 – Computation of Allowable Cost and Cost Settlement;

(3) Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance;

(4) A Mapping of the Trial Balance which shows the tracing of each Trial Balance account to a line and column on worksheet 1 of the Cost Report;

(5) Documentation supporting the Provider's reclassification and adjustments;

(6) A Schedule of Depreciation of depreciable assets;

(7) Listing of all satellites if applicable; and

(8) Federal Grant Award notices or changes in scope approved by HRSA.

(m) Once the base rate for an FQHC has been calculated, the FQHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (n), a cost report shall only be required if the FQHC is seeking to adjust its effective rate.

(n) New FQHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. FQHC shall file a cost report within five (5) months of the end of FQHC's initial fiscal year. The cost settlement must be completed within eleven (11) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new FQHC location established by an existing FQHC participating in the Medicaid program shall receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(o) In the event that the total amount paid to an FQHC by a managed care organization is less than the amount that the FQHC would receive under PPS, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the ~~baseline payment under the~~

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contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient cost or bonuses.

(p) Submission of Audited Medicare Cost Reports. An FQHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.

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31. Federally Qualified Health Centers (FQHC):

For services provided by an FQHC and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

FQHCs may be reimbursed using an alternative payment methodology. Written and signed agreements will be obtained from all FQHC providers agreeing to the alternative methodology.

(a) In accordance with Section 1902 (aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the FQHC fiscal year which includes dates of service occurring January 1, 2001, and after, each FQHC will be reimbursed a per visit rate for Medicaid covered services with cost settlement at the greater of 100% of reasonable costs or the allowable per visit rate as determined under the prospective payment system (PPS). Cost settlements will be determined from provider submitted cost reports.

(b) The PPS per visit rate for each FQHC will be calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years.

(c) The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.

(d) Prior to the commission setting a final base rate pursuant to the alternative PPS methodology outlined in Subsection (a), each FQHC shall be reimbursed on the basis of an interim per visit rate. The interim per visit rate for each FQHC will be the encounter rate from the latest finalized cost report settlement, as adjusted pursuant to Subsection (i) of the alternative PPS methodology. When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001. If the total payments under the interim rates are less that the total amount calculated pursuant to Subsection (a), an adjustment will be made to account for the difference. If the interim payments are greater than the base rate calculation no reconciliation shall occur. The final base rate, as adjusted, shall apply prospectively from the date of final approval.

(e) Reasonable costs, as used in setting the base rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413 with no productivity screens and no per

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visit payment limit. The administrative cost limit of thirty percent (30%) of total costs that was in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.

(f) Unallowable costs are expenses which are incurred by an FQHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:

(1) Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(2) Personal expenses not directly related to the provision of covered services;

(3) Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(4) Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(5) Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(6) Political contributions;

(7) Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(8) Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;

(11) Entertainment expenses except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director's fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

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(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the FQHC;

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(22) Overhead costs beyond the 30% limitation established by HHSC.

(g) A visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The FQHC patient has a medical visit and an "other" health visit.

(h) A medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse mid-wife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face encounter between an FQHC patient and a clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, a Texas Health Steps Medical Screen, or a health care orientation as required by HHSC.

(i) Effective for each FQHC's fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an FQHC's base per visit rate or the effective rate shall be the rate of change in the Medical Economic Index (MEI) for primary care plus one and one-half percent (1.5%). If the increase in an FQHC's reasonable costs is greater than the MEI plus one and one-half percent for any fiscal year an FQHC may request an adjustment of its effective rate equal to one hundred percent (100%) of reasonable costs.

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(j) The effective rate is the rate paid to the FQHC for the current fiscal year. The effective rate equals the base rate plus the MEI plus one and one-half percent (1.5%) for each of the FQHC's fiscal years since the setting of its base rate. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year.

(k) An adjustment shall be made to the effective rate if the increase in an FQHC's reasonable costs are greater than the MEI plus one and one-half percent (1.5%) for any fiscal year in which the FQHC can show that it is operating in an efficient manner or that the increase is due to a change in scope. An FQHC may request an adjustment of its effective rate equal to one hundred percent (100%) of reasonable costs by filing a cost report and the necessary documentation to support a claim that it is operating in an efficient manner or has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an FQHC's fiscal year but no later than five (5) calendar months after the end of the FQHC's fiscal year. All requests for adjustment in the FQHC's effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation supporting the FQHC's claim that it is operating in an efficient manner or has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

(l) Any request by an FQHC to adjust its effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope.

(m) Operating in an efficient manner shall include a showing that:

(1) The FQHC has implemented an outcome-based delivery system which includes prevention and chronic disease management. Prevention includes, but is not be limited to, programs such as immunization and medical screens. Disease Management shall include, but not be limited to, programs such as diabetes, cardiovascular and asthma which can demonstrate an overall improvement in patient outcomes; and

(2) The FQHC is:

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(A) Paying employee's salaries which do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

(B) Providing fringe benefits to its employees which do not exceed 12% of the FQHC's total costs;

(C) Implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

(D) Employing the Medicare concept of a "prudent buyer" in purchasing its contracted medical services.

(n) A change in scope of services provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an FQHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(o) A workable cost report includes the following:

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(1) An FQHC Statistical Data Coversheet with Certification by an Officer or Administrator;

(2) Medicaid Cost Report consisting of three (3) worksheets:

(A) Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses;

(B) Worksheet 2 – Provider Staff and Encounters; and

(C) Worksheet 3 – Computation of Allowable Cost and Cost Settlement;

(3) Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance;

(4) A Mapping of the Trial Balance which shows the tracing of each Trial Balance account to a line and column on worksheet 1 of the Cost Report;

(5) Documentation supporting the Provider's reclassification and adjustments;

(6) A Schedule of Depreciation of depreciable assets;

(7) Listing of all satellites if applicable; and

(8) Federal Grant Award notices or changes in scope approved by HRSA.

(p) Once the base rate for an FQHC has been calculated, the FQHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (q), a cost report shall only be required if the FQHC is seeking to adjust its effective rate.

(q) New FQHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. FQHC shall file a cost report within five (5) months of the end of FQHC's initial fiscal year. The cost settlement must be completed within eleven (11) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new FQHC

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location established by an existing FQHC participating in the Medicaid program shall receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(r) In the event that the total amount paid to an FQHC by a managed care organization is less than the amount that the FQHC would receive under Section 1902(aa)(1-4) of the Social Security Act, as applicable, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient cost or bonuses.

(s) It is the intent of the state to assure that centers are reimbursed at 100% of their reasonable costs or the adjusted PPS rate, which ever is greater. If the state can show that an FQHC is being reimbursed at an effective rate which exceeds one hundred and two percent (102%) of its reasonable costs, it may reduce the FQHC's effective rate to a rate which reflects 100% of its reasonable costs or the PPS rate without adjustments, which ever is greater. Any such adjustment in an FQHC's effective rate shall only be applied prospectively. The state may request that a center file a cost report for its most current fiscal year, plus any revisions to the cost report, within five (5) months, when evidence indicates that an FQHC is receiving excess reimbursement. The adjusted PPS rate shall mean the base rate plus subsequent increases as defined herein, excluding any adjustment in the effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate. Payments made under this alternative methodology will at least be equal to what would have been paid under PPS.

(t) Submission of Audited Medicare Cost Reports. An FQHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Calvin G. Cline
Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

November 13, 2001

Our reference: SPA-TX-01-01

Ms. Linda K. Wertz, State Medicaid Director
Texas Health and Human Services Commission
Post Office Box 13247
Austin, TX 78711

Dear Ms. Wertz:

We have reviewed the proposed amendment to your Medicaid State plan submitted under transmittal no. (TN) 01-01, including the revisions submitted on October 30, 2001. This amendment revises the payment methodology for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Effective for services on or after January 1, 2001, RHCs and FQHCs will have a choice between being paid a prospective all-inclusive rate or an alternative methodology conforming to the provisions of Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

Based on the information you submitted we have approved the amendment for incorporation into the official Texas State plan, effective for services on or after January 1, 2001. We have enclosed a copy of HCFA-179, TN 01-01 dated November 13, 2001, and the amended plan pages.

If you have any questions, please call Billy Bob Farrell at (214) 767-6449.

Sincerely,

Calvin G. Cline

Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosures

cc: Elliot Weisman, CMSO, PCPG
Commerce Clearing House

CMS
CENTERS for MEDICARE & MEDICAID SERVICES